

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

February 3, 2017

Ms. Melissa Greason, Manager  
Washington Elms  
126 Elm Street  
Bennington, VT 05201-2232

Dear Ms. Greason:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on January 4, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief



JAN 30 2017

PRINTED: 01/17/2017  
FORM APPROVED

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 01/04/2017
NAME OF PROVIDER OR SUPPLIER  WASHINGTON ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 126 ELM STREET BENNINGTON, VT 05201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
R100	Initial Comments:  An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 1/4/17. There were regulatory findings.	R100	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.9.c (2)  Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have care plans for 2 of 4 residents, Resident #1 and #2, that reflect behaviors. Findings include:  1.) Resident #1 has documented behaviors of verbal and mental abuse toward residents and staff, his/her current care plan reflects the assistance needed and safety. The interventions include teaching regarding safety for ambulation/transfers with mobility device, proper nutrition NCS diet, personal care needs and appropriate interactions with staff. There is nothing to address his/her behavior and what the staff should do when it occurs. Per the Registered Nurse at 11:23 AM, s/he stated that there are no care plans or staff interventions to address specific behaviors.	R145	1/25/17 BEHAVIOR CARE PLAN TO ADDRESS TRIGGERS, INTERVENTIONS AND DESIRED OUTCOMES. COMPLETED AND REVIEWED WITH STAFF TO BE IMPLEMENTED IMMEDIATELY. CARE PLAN ATTACHED FOR REVIEW.  _____ MUTTER 1-25-17

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

5899

74NH11

If continuation sheet 1 of 6

R145 - R224 POCs accepted 2/2/17 BOUTER/PM

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 01/04/2017
NAME OF PROVIDER OR SUPPLIER  WASHINGTON ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 126 ELM STREET BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	Continued From page 1  2.) Resident #2 has diagnoses which include: Bipolar disorder; ETOH abuse and Personality disorder. There is documentation in the medical record that Resident #2 will leave the facility in the company of another resident and they like to spend time alone together and per the owner, s/he needs to be reminded that s/he has a roommate and that having the other resident in his/her room is not appropriate. Per the Registered Nurse (RN) the two residents spend a great deal of time together and they will often leave the facility together and not always return when stated that s/he will. Per the RN there is no legal guardian and s/he makes sis/her own decisions, even though sometimes they are not good choices. The care plans reflect smoking precautions and assistance required for care. The RN confirmed at 11:25 AM that there is no care plan to address what interventions the staff should have in regards to the behavior with the other resident.	R145	CARE PLAN UPDATED TO ADDRESS INTERVENTIONS TO BE IMPLEMENTED WITH RESIDENT REGARDING HOUSE RULES MALES NOT BEING ALLOWED IN FEMALE RESIDENT BEDROOMS. RESIDENTS INSTRUCTED TO CLOSE BEDROOM DOORS WHEN DRESSING + UNDESSING. DOORS POSTED WITH SIGNS FOR VISUAL REMINDERS. RESIDENT #2 ENCOURAGED TO VISIT WITH RESIDENT #1 IN HIS PRIVATE BEDROOM TO WATCH TV WITH DOOR OPEN.	
R191 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.12 Records/Reports  5.12.c A home must file the following reports with the licensing agency:  5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file.	R191		

— Multi RE rd 1/25/17

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/04/2017</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WASHINGTON ELMS**

**126 ELM STREET  
BENNINGTON, VT 05201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R191	Continued From page 2  5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file.  5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained.  5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours.  5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency.  5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to report incidents of abuse to the licensing agency. Findings include:  Per record review for Resident #1, there was documentation regarding the resident being	R191		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  C 01/04/2017
NAME OF PROVIDER OR SUPPLIER  WASHINGTON ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 126 ELM STREET BENNINGTON, VT 05201			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R191	Continued From page 3  verbally and mentally abusive on different occasions.  1.) On 6/26/16 the resident was brought upstairs and was upset about another resident in his/her chair and stomped his/her foot and growled at the other resident. Per the Registered Nurse, this upset the other resident, but s/he did not verbalize. 2.) On 7/24/16 Resident #1 made rude comments toward Resident #2, saying s/he smelled and need to shower and that s/he was disgusting. Comments were made in front of everyone in the dining room and another resident told him/her that it was rude and to stop, but h/she continued to insult the resident. 3.) On 9/13/16 the 3-11 staff documented that Resident #1 was agitated with another resident that was sitting in the hallway at the round table and yelled at him/her. Resident #1 continued to yell and swear at the resident, until the resident got up and went into their room. After staff spoke with Resident #1 about the incident, s/he continued to yell at another resident at the elevator and say that 'one of these days s/he is going to knock someone's head off'. Review of these notations in the record of Resident #1 with the Registered Nurse and the owner at 11:15 AM and they both confirmed that none of these incidents had been reported to the Licensing Agency and agreed that they could be considered abusive. 4.) Resident #3 had made complaints that Resident #1 had been touching him/her after being told not to. Per interview with the owner and the Registered Nurse at 11:15 AM, they felt that after investigating the complaint, that Resident #2 had been holding hands with Resident #1 prior to the incident and they felt that it was harmless. The owner confirmed at this	R191	1/25/17  INSERVICE SCHEDULED FEB 22, 2017. REPORTING ABUSE, NEGLECT + EXPLOITATION  INSERVICE 1-25-17 WORKING WITH DIFFICULT + COMBATIVE PEOPLE.  REVIEWED POSTED RESIDENT RIGHTS + PHONE NUMBERS TO REPORT TO APS. STAFF INSTRUCTED TO REPORT ANY / ALL INCIDENTS VERBAL ABUSE BETWEEN RESIDENTS TO OWNER / RN.  — WHITE RN 1-25-17		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 01/04/2017
NAME OF PROVIDER OR SUPPLIER  WASHINGTON ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 126 ELM STREET BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R191	Continued From page 4  time that the allegation of inappropriate touching was not reported. 5.) On 12/10/16 Resident #1 was in the living room swearing and threatening another resident that he was going to physically harm him. Per the confirmation of the owner at 11:15 AM, s/he did not feel that Resident #1 would actually harm the other resident and the Registered Nurse stated that Resident #1 likes to present as a bully and per reports from the family, s/he has always been like this. Both stated at this time that the incident had not been reported.	R191		
R224 SS=D	VI. RESIDENTS' RIGHTS  6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.  This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to insure that residents were free from verbal or mental abuse from one resident, Resident #1. Findings include:  Review of the medical record for Resident #1, on 1/4/17 had documentation to support that s/he was disruptive and would yell, swear and threaten others. 1.) Per client notes in record of Resident #1, on 6/26/16 s/he was brought upstairs and was upset about a resident in his/her chair and stomped his foot and growled at the resident and per interview with the Registered Nurse at 11:23 AM, this upset the resident that Resident #1 had directed his/her	R224		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 01/04/2017
NAME OF PROVIDER OR SUPPLIER  WASHINGTON ELMS		STREET ADDRESS, CITY, STATE, ZIP CODE 126 ELM STREET BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R224	Continued From page 5  anger at. 2.) On 7/24/16, Resident #1 made rude comments toward Resident #2 saying s/he smelled and needed to shower and that s/he was disgusting. Comments were made in front of everyone in the dining room. 3.) Documentation by the 3-11 shift on 9/13/16 presents that Resident #1 was agitated tonight with another resident sitting in hallway at round table. H/she yelled at the other resident and was swearing at the resident until they got up and quickly went into their room. Staff spoke to Resident #1 and told him/her that s/he shouldn't be swearing and yelling at people. Resident #1 then got on the elevator and yelled at another resident stating that 'one of these days I'm going to knock someone's head off. 4.) On 10/8/16 Resident #3 complained of Resident #1 touching him/her after being told not to. On 10/10, staff spoke with Resident #1 and instructed that s/he was not allowed to touch other residents. Reviewed with the owner and s/he confirmed at 11:15 AM that this would be considered abusive and that all the residents residing in the facility are potentially affected by his behavior. The Registered Nurse confirmed at 11:23 AM that the staff are aware that they are to intervene and redirect Resident #1 to his/her room when s/he becomes threatening, but there is no written care plan to address the behaviors.	R224	1/25/17 BEHAVIOR CARE PLAN COMPLETED + REVIEWED WITH STAFF TO BE IMPLEMENTED IMMEDIATELY. REVIEWED RESIDENT RIGHTS POSTING WITH APS PHONE NUMBER + MANDATORY REPORTING REQUIREMENTS. — MULTITEN	